No. 84-325
No. 84-356

In the Supreme Court

of the United States

OCTOBER TERM 1984

METROPOLITAN LIFE INSURANCE COMPANY, *Appellant*, v. COMMONWEALTH OF MASSACHUSETTS, *Appellee*.	)	No. 84-325
THE TRAVELERS INSURANCE COMPANY, *Appellant*, v. COMMONWEALTH OF MASSACHUSETTS, *Appellee*.	)	No. 84-356

ON APPEAL FROM THE SUPREME JUDICIAL COURT FOR THE COMMONWEALTH OF MASSACHUSETTS

BRIEF AMICUS CURIAE

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AMICUS CURIAE BRIEF

ISSUE PRESENTED FOR REVIEW

Whether a state law mandating benefits in insurance policies purchased by employee benefit plans is preempted by § 514 of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1144, or by the National Labor Relations Act, 29 U.S.C. § 151 et seq.

INTEREST OF AMICI CURIAE

This brief filed by Milton R. Hill, et al., supports appellants The Travelers Insurance Company and Metropolitan Life Insurance Company in the above appeals.

Amici are trustees of Sheet Metal Workers Local 16 Health & Welfare Trust, an employee benefit plan established under collective bargaining agreements to provide health care benefits for employees of more than 100 Oregon and Washington employers. In March 1984 the trustees brought an action in the District Court for Oregon to prevent the state's Insurance Commissioner from enforcing statutes mandating benefits in group health insurance policies purchased by multi-employer plans. They alleged that the statutes are preempted by § 514(a) of ERISA, and sought declaratory and injunctive relief. *Hill* v. *Driscoll*, Civ. No. 84-287.[1]

[1] Oregon statutes (Appendix A) mandate benefits in "Group Health Insurance" policies, including policies issued to a multi-employer fund. O.R.S. 743.522(3). The trustees of (footnote continued)

The district court concluded that the Oregon statutes "regulate insurance" and are saved from preemption by § 514(b)(2)(A) of ERISA. It entered summary judgment in favor of defendants, and the trustees appealed to the Ninth Circuit Court of Appeals. Their appeal has been stayed pending a decision of this Court in *Travelers* and *Metropolitan Life*.

Clearly, the decision in *Travelers* and *Metropolitan Life* will be important to a final decision in *Hill* v. *Driscoll*. However, the interests of insurance companies asserted in those cases are not the true measure of their significance to welfare benefit plans under ERISA. The adverse impact on insured plans of state laws mandating benefits in health insurance policies can be severe, as in the case of Local 16, in which the trustees' fiduciary obligations and the economics of the plan they administer make mandated benefits a heavy burden which threatens employers and beneficiaries alike with higher costs and reduced benefits.

SUMMARY OF ARGUMENT

The most serious impact of the decision below is on insured plans which must pay the increased premiums

(footnote carried forward)
Local 16 objected to requirements that their policy provide a specified level of chemical dependency treatment (alcoholism) (O.R.S. 743.557); services of clinical social workers (O.R.S. 743.135); and maxillofacial prosthetic services (O.R.S. 743.119). Those are only some of the benefits mandated by Oregon statutes at the instance of interested groups of providers. See O.R.S. 743.132 (denturist services) and O.R.S. 743.558 (treatment of mental and nervous conditions).

that are generated by mandated benefits. Under that decision, trustees cannot insure a plan's obligations without losing control over benefits and costs, on the untenable ground that the state regulation falls on the policy and not the plan.

This result is hostile to § 514, which, as interpreted in *Alessi*, preempts all state regulation of ERISA plans and relies on the collective bargaining process and decisions of plan fiduciaries to define plan benefits. That federal policy prevents the indirect assertion of state control over ERISA plans by regulating insurance benefits which constitute plan benefits.

ARGUMENT

1. Mandated insurance benefits have a severe adverse effect on benefit plans which, like Local 16's, are not self-insured.[2]

Local 16's plan covers employees of more than 100 employers in the sheet metal industry in Oregon and Washington, and is financed by employers' contributions under collective bargaining agreements. Benefits include hospital/medical and major medical coverages, which are provided under a group health insurance policy from Blue Cross and Blue Shield of Oregon (BC/BSO). The plan is administered by three trustees

[2] The problem facing Local 16's trustees in dealing with the Oregon statutes is reviewed because it illustrates the dilemma of all trustees of insured plans. The affiants are two of the trustees of Local 16's benefit plan. Their affidavits were filed in the summary judgment proceedings in the District Court.

representing employers and three representing the employees. The trustees determine plan benefits and perform administrative functions, and while most benefit decisions are made by consensus (Hill Aff. 6), the employee trustees initiate most benefit changes (Archer Aff. 3).

In recent years, there has been a severe "financial squeeze" on Local 16's plan. The recession reduced employers' contributions by reducing the number of members working and by limiting the available hours of work and the negotiated level of employer contributions per hour worked (Archer Aff. 3-4; Hill Aff. 5). This led to a "squeeze," because the plan pays BC/BSO a full premium for each eligible member and his dependents, although the employer contributes only for hours actually worked (Archer Aff. 4).

This loss of income has been accompanied by "dramatic increases in benefit costs" exceeding the rate of inflation, and as a result plan contributions by employers are less than premiums; reserves are subsidizing current coverage, and reduced benefits are a possibility (Archer Aff. 4-6). From January to October 1983 the average contribution per employee, based on hours worked, was $134.56. The BC/BSO premium per member was $151.71 (Archer Aff. 4).

To deal with these problems, the trustees took two steps. First, they concluded that it would not be prudent to provide coverage on an uninsured basis, and that the plan should provide hospital/medical and

major medical benefits under an insurance policy from BC/BSO (Archer Aff. 2-3; Hill Aff. 5). Proceeding without insurance "would expose our trust and its thousands of beneficiaries to unacceptable risk, especially in view of the current financial squeeze" (Archer Aff. 3; see Hill Aff. 5).

Second, the trustees acted to modify or eliminate certain benefits that Oregon law requires in health insurance policies sold to multi-employer plans. They reduced the benefit for "chemical dependency" (alcoholism) treatment below the level prescribed by statute in 1981 and 1983, and eliminated benefits for the services of clinical social workers and for maxillofacial prosthetic services (Archer Aff. 5; Hill Aff. 6-8). These mandated coverages involve significant costs during a contract period in which increased costs cannot be recovered by increased contributions (Archer Aff. 6).

The continued availability of basic coverages is important to plan members (Hill Aff. 5), and the trustees took these actions only after careful consideration and consultation with their professional advisors and their members, and after evaluating their financial resources (Hill Aff. 2-4, 6; Archer Aff. 6-7).

2. Congress's intent to preempt regulation of ERISA plans is inconsistent with state laws which mandate coverages in insurance policies purchased to provide ERISA plan benefits.

a. The Congressional intent to preempt state regulation of ERISA plans, including plan benefits, has

been given substance by decisions of this Court interpreting § 514 of the Act, *Alessi* v. *Raybestos-Manhattan, Inc.*, (1981) 451 U.S. 504, subject only to "narrow, specific exceptions" in the statute. *Shaw* v. *Delta Air Lines, Inc.*, (1983) — U.S. —, 77 L. Ed.2d 490, 505, 103 S.Ct. 2390. In *Alessi*, a plan which coordinated benefits received under state law was protected by preemption from a state statute forbidding coordination of Workers' Compensation benefits. As applied to an ERISA plan, the statute "related to" the plan and was preempted. Under *Alessi*, the regulation of ERISA plans is "exclusively a federal concern," and benefit decisions are protected from state interference. 451 U.S. at 523-24.

In *Shaw* v. *Delta Airlines, supra*, the Court reviewed the legislative history of ERISA and held that § 514 should be given broad effect, subject only to "narrow, specific exceptions" in the Act.[3] *Shaw* gives no encouragement to the view that those narrow exceptions will be allowed to interfere with the overriding purpose of § 514 to free ERISA plans from state regulation.

b. State mandated insurance benefit statutes unlawfully regulate ERISA benefits by regulating benefits in policies that provide plan benefits. The policy benefits, absent state regulation, reflect the

[3] In *Franchise Tax Bd.* v. *Laborers Vac. Trust*, (1984) — U.S. —, —, n. 26, 77 L. Ed.2d 420, 440, 103 S.Ct. — the Court referred to § 514 as a "virtually unique preemption provision."

decisions of plan fiduciaries acting under collective bargaining agreements and ERISA fiduciary standards, and its provisions defining and limiting policy benefits merely carry out decisions about plan benefits which the State cannot regulate.

Even if this plan had a true choice, and could prudently elect between insuring and self-insuring its obligations, an insurance policy would be an attractive or even important option, by committing to payment of benefits and by providing claim services. In such cases, a plan that wishes to have the benefits of insurance must, like one that has no choice, give up its control over plan benefits and costs if state regulation can mandate policy benefits.

c. For Local 16 the effect is severe. The trustees of Local 16's plan have determined after careful study that prudent management requires them to insure plan benefits and eliminate marginal benefits. Their effort to bring income and expenses into line, while preserving basic coverages for plan members, is threatened with state regulation that imposes costly and unwanted services on their plan.

These trustees face a Hobson's choice. They can take imprudent action and self-insure the plan, or they can provide mandated coverages which exacerbate their financial problem and interfere with their determination of plan benefits. That interference, through the pretense of regulating an essential insurance policy,

dictates plan benefits precisely as if the Oregon law operated directly on the plan itself.

The "narrow, specific exception" in § 514(b)(2)(A) for statutes regulating insurance does not compromise Congress's intent to exclude the states from any role in regulating ERISA plans. State laws mandating insurance benefits are preempted by § 514, because their primary purpose and effect is not to assure the integrity of insurers or the payment of benefits to plan members, but to control plan benefits.

CONCLUSION

Amici support the appeals of *Travelers* and *Metropolitan Life* and ask the Court to reverse the judgment.

Respectfully submitted,

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APPENDIX A

O.R.S. 743.522 "Group health insurance" defined.

" 'Group health insurance' means that form of health insurance[4] covering groups of persons as defined in this section, with or without one or more members of their families or one or more of their dependents, or covering one or more members of the families or one or more dependents of such groups of persons, and issued upon one of the following bases:

* * * * *

"(3) Under a policy issued to the trustees of a fund established by two or more employers in the same or related industry or by one or more labor unions or by an association as defined in subsection (2) of this section, which trustees shall be deemed the policy-holder, insuring employes of the employers or members of the unions or of such association, or employes of members of such association for the benefit of persons other than the employers or the unions or such association * * *."

O.R.S. 743.557 Group health insurance coverage for treatment for chemical dependency including alcoholism; limitation on deductibles and coinsurance; eligible treatments and programs; allowable limits on payments; cost containment.

"A group health insurance policy providing coverage for hospital or medical expenses shall provide coverage for expenses arising from treatment for chemical dependency including alcohol-

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[4] Health insurance is defined in O.R.S. 731.162.

ism. The following conditions apply to the requirement for such coverage:

* * * * *

"(2) Treatment shall include treatment provided in health facilities, residential facilities or outpatient services, as defined in O.R.S. 430.010, within the limits specified in this section. Notwithstanding the limits for particular types of services specified in subsections (6) to (8) of this section, a policy may limit the total of payments for all treatment of any kind under this section for chemical dependency including alcoholism, together with payments for all treatment of any kind under O.R.S. 743.558 for mental or nervous conditions, to $6,000 in any 24-consecutive month period, except as otherwise provided in O.R.S. 743.558. For persons requesting, in any 24-consecutive month period, payments for treatment of any kind for chemical dependency including alcoholism, but not requesting payments for treatment of any kind of mental or nervous conditions, a policy may limit the total of payments for all treatment to $6,000 in that 24-consecutive month period."

O.R.S. 743.135 Reimbursement for services of clinical social worker.

"Whenever any individual or group health insurance policy provides for payment or reimbursement for any service which is within the lawful scope of service of a clinical social worker registered under O.R.S. 675.510 to 675.610:

"(1) The insured under the policy shall be entitled to the services of a clinical social worker registered under O.R.S. 675.510 to 675.610, upon referral by a physician or psychologist."

O.R.S. 743.119 Reimbursement for maxillofacial prosthetic services.

"(1) The Legislative Assembly declares that all group health insurance policies providing hospital, medical or surgical expense benefits include coverage for maxillofacial prosthetic services considered necessary for adjunctive treatment."